The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES
COUNTY TUBERCULOSIS HOSPITALS

A hospital defined and licensed as a County Tuberculosis hospital shall be entitled to Medicaid payment for authorized Medicaid services provided to eligible persons, in accordance with Medicare reasonable cost recognition principles using an all-inclusive **prospective** payment rate for such services. Such hospitals shall be limited to Medicaid reimbursement representing recognition of and payment for the lower of the following: (a) the reasonable cost of services delivered as developed through the applicable **prospective** reasonable cost principles applicable to Title XVIII, or (b) the customary charges to the general public. The upper limits for Medicaid payment of inpatient services to hospitals shall not exceed in the aggregate, the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

The Indiana Medicaid program prohibits hospitals from charging the Medicaid program for items or services furnished to Medicaid recipients which are more expensive than those determined to be necessary in the efficient delivery of health services.

The Medicare reasonable cost recognition principles used to establish an all-inclusive prospective payment rate for County Tuberculosis Hospitals involves a comprehensive audit of the hospital's 1991 Medicaid cost report (base year), organizing the facility's costs into logical cost groupings for allocation to major cost centers and eliminating excessive and unallowable costs. This step down method of capturing costs in described in detail in the CFR at 42 CFR 413.24 (d)(1). After arriving at allowable costs including ancillaries, those costs are divided by Medicaid inpatient days to arrive at an all-inclusive daily per diem. This 1991 rate is then inflated to the midpoint of the year for which it is used prospectively by the hospital using the DRI-MCGRAW HILL HOSPITAL MARKETBASKET INDEX.

MEDICAID INPATIENT SERVICES HOSPITAL REIMBURSEMENT ADD-ON PAYMENT METHODOLOGY TO COMPENSATE HOSPITALS THAT DELIVER HOSPITAL CARE FOR THE INDIGENT PROGRAM SERVICE

In order to be eligible and receive a payment under the Indiana Hospital Care for the Indigent Care (HCI) program, a hospital must be enrolled in and be providing inpatient services to the Indiana Medicaid program during the state fiscal year for which payment is being made and must have an audited cost report from the most recent common state fiscal year for which audited cost reports are on file with the office for all potentially eligible hospitals on June 30 of a preceding state fiscal year, unless extenuating circumstances exist. Hospitals that are no longer accepting Medicaid and HCI patients shall not receive payment under this section. This Medicaid add-on payment will compensate eligible hospitals for providing services to recipients in the HCI program and will be calculated and paid using the formula set forth below.

An eligible hospital for HCI purposes is defined as an acute care hospital licensed under Indiana Code 16-21, as defined and interpreted in the disproportionate share payment section of the Indiana Medicaid state plan amendment, and as defined and interpreted under the prior Medicaid HCI add-on payment methodology. I.C. 12-15-15-8 contained the payment methodology that was used to determine and make payments under the HCI program prior to state fiscal year 1998 and therefore, will not be used to calculate the payments for each state fiscal year beginning July 1, 1997 and thereafter.

PAYMENT FORMULA

According to I.C. 12-15-15-9, for each state fiscal year beginning July 1, 1997 and thereafter, the total Medicaid HCI add-on payments to hospitals for a state fiscal year shall be equal to all amounts transferred from the hospital care for the indigent fund for Medicaid current obligations during the state fiscal year, including amounts of the fund appropriated for Medicaid current obligations. The payment due to a hospital must be based on a policy developed by the Office of Medicaid Policy and Planning (the office). The policy is not required to provide for equal payments to all hospitals; must attempt, to the extent practicable as determined by the office, to establish a payment rate that minimizes the difference between the aggregate amount paid to all hospitals in a county for a state fiscal year and the amount of the county's hospital care for the indigent property tax levy for that state fiscal year; and must provide that no hospital will receive a payment less than the amount the hospital received under IC 12-15-15-8 for the state fiscal year ending June 30, 1997.

STEP 1: Determine the state fiscal year ending June 30, 1997 Medicaid HCI add-on payments for each hospital individually and in the aggregate.

If a hospital that was entitled to a Medicaid HCI add-on payment is either acquired by or merges with another hospital within the same city limits and/or county prior to or during the state fiscal year for which payment is being made, the payment due to the hospital shall be paid to the acquiring or merged hospital within the same city limits and/or same county, regardless of whether the acquiring or merged hospital is separately licensed or has a separate Medicaid provider number.

If a hospital that was entitled to a Medicaid HCI add-on payment is either acquired by or merges with another hospital outside the city and county limits prior to or during the state fiscal year for which payment is being made, but is no longer accepting patients for inpatient and outpatient services prior to or during the state fiscal year for which payment is being made, the payment due to the hospital shall not be paid to the acquiring or merged hospital and shall be distributed in accordance with STEP 8.

If a hospital that was entitled to a Medicaid HCI add-on payment is no longer accepting inpatient and outpatient services at the time payment is made for state fiscal year ending 1997 and thereafter, the payment due to the hospital shall be paid proportionately to all other hospitals entitled to payments, if any, within the same city limits in accordance with STEP 8. If no other hospitals entitled to payments are located within the same city limits, the payments shall be paid proportionately to all other hospitals entitled to payments located in the same county in accordance with STEP 8.

If the total hospital care for the indigent property tax levy from the most recent state fiscal year that is available does not exceed the total Medicaid HCI add-on payments made under I.C. 12-15-15-8 for state fiscal year ending June 30, 1997, then the hospitals that received payments under I.C. 12-15-15-8 for state fiscal year ending June 30, 1997 shall receive payments proportionately reduced. The payments shall be proportionately reduced by the following manner:

STEP 1a: Divide the Medicaid HCI add-on payment paid to each hospital under I.C. 12-15-15-8 for state fiscal year ending June 30, 1997 by the total amount paid under I.C. 12-15-15-8 from state fiscal year ending June 30, 1997.

STEP 1b: Multiply each hospital's state fiscal year ending June 30, 1997 payment percentage determined in STEP 1a by the total hospital care for the indigent property tax levy from the most recent state fiscal year that is available to determine each hospital's county equity payment.

When the total hospital care for the indigent property tax levy from the most recent state fiscal year does not exceed the total Medicaid HCI add-on payments made under I.C. 12-15-15-8 for state fiscal year ending June 30, 1997, all hospitals that did not participate in the HCI program under I.C. 12-15-15-8 for state fiscal year ending June 30, 1997 shall not receive a payment for the state fiscal year for which payment is being made.

STEP 2: Calculate the state fiscal year ending June 30, 1997 Medicaid HCI add-on payments paid to each county individually and in the aggregate.

STEP 3: Determine each county's most recent hospital care for the indigent property tax levy that is available.

STEP 4: Subtract the total state fiscal year ending June 30, 1997 Medicaid HCI add-on payments for each county from each county's most recent hospital care for the indigent property tax levy that is available.

STEP 5: At the discretion of the office, determine the total county equity payment amount from the amount above the $35,000,000.00 that is transferred for Medicaid current obligations.

STEP 6: Divide the specific county deficit for each county with a deficit that have one or more hospitals located in the county from the most recent state fiscal year that is available by the total county deficit of counties with a deficit that have one or more hospitals located in the county from the most recent state fiscal year that is available.

STEP 7: Multiply the total county equity payment amount calculated in STEP 5 by the specific county deficit percentage determined in STEP 6.

STEP 8: Determine the allowable Medicaid inpatient day(s) for each hospital. An allowable Medicaid inpatient day is defined as a Medicaid inpatient day that was allowed and paid for by the Indiana Medicaid program during a fiscal year for the eligible hospital and a verifiable out-of-state Medicaid inpatient day. The Medicaid inpatient day shall be based on utilization data from the most recent common state fiscal year for which an audited cost report from the hospital is on file with the office for all potentially eligible hospitals on June 30 of a preceding state fiscal year as derived from the disproportionate share eligibility database. For purposes of calculating a HCI Medicaid inpatient day, audited is defined as a targeted limited scope desk review where the data used for HCI calculation is thoroughly reviewed and adjusted where necessary. If a cost report is not based on a full year's worth of data, then the Medicaid inpatient days may be annualized to reflect a full year's worth. The office may use an audited cost report from a fiscal year that is prior to or after the most recent common state fiscal year that is being used for all potentially eligible hospitals based on extenuating circumstances only, as determined by the office. Extenuating circumstances does not include comparing the utilization data of a hospital from different fiscal years to derive the most advantageous days for payment purposes.

If the hospital is new and has an audited cost report on file that can be used, then the hospital's Medicaid inpatient days from that audited cost report must be used. If a hospital is no longer enrolled in and is not providing inpatient services to the Indiana Medicaid Program during the state fiscal year for which payment is being made, then the hospital's Medicaid inpatient days shall be excluded from the calculation.

If a hospital that is entitled to a Medicaid HCI add-on payment is either acquired by or merges with another hospital within the same city limits and/or same county prior to or during the state fiscal year for which payment is being made under I.C. 12-15-15-9, and the acquiring hospital has or the merged hospitals have an audited cost report on file that can be used, then the acquiring or merged hospital's Medicaid inpatient days from that audited cost report must be used. The Medicaid inpatient days from the acquired hospital or hospitals prior to the merger shall be excluded from the calculation. If the acquiring hospital does not or the merged hospitals do not have an audited cost report on file that can be used, then the acquired hospital's or merged hospitals' Medicaid inpatient days from the most recent audited cost report on file can be used.

STEP 9: Calculate the total Medicaid inpatient days for each county individually from the most recent state fiscal year for which an audited cost report is on file for each hospital located within the county.

STEP 10: Divide the specific hospital's Medicaid inpatient days by the total Medicaid inpatient days for the county within which the hospital is located.

STEP 11: Multiply the remaining specific county's tax levy amounts from the most recent state fiscal that is available or any other remaining amount by the remaining specific hospital's percentage.

STEP 12: Add the state fiscal year ending June 30, 1997 Medicaid HCI add-on payments for each hospital to each hospital's county equity payment amount for the state fiscal year for which payment is being made.

STEP 13: For whatever reason, if there is a remaining total county equity payment amount, at the discretion of the office, the remaining total county equity payment amount will be distributed in the following manner:

STEP 14: At the discretion of the office, determine any total county equity payment amount remaining.

STEP 15: Divide each county's specific tax levy amount from the most recent state fiscal year that is available in STEP 3 by the total state hospital care for the indigent property tax levy amount from the most recent state fiscal year that is available to determine each county's most recent hospital care for the indigent property tax percentage.

STEP 16: Determine each county's most recent hospital care for the indigent property tax percentage.

STEP 17: Multiply each county's most recent hospital care for the indigent property tax percentage from STEP 16 by the remaining total county equity payment amount in STEP 14.

STEP 18: Proceed to STEP 8 to complete the process.

Payment shall be disbursed annually prior to or after the end of the state fiscal year for which payment is applicable.

EFFECTIVE DATE

Subject to approval by HCFA, these payment adjustments are to be effective on or after April 1, 1999. Payments being made beginning effective April 1, 1999 for SFYE June 30, 1999 and thereafter shall be paid by this methodology.

REIMBURSEMENT FOR ALL OTHER INPATIENT HOSPITAL SERVICES

PROSPECTIVE REIMBURSEMENT METHODOLOGY

A prospective cost-based payment rate for each hospital stay will be established according to a DRG reimbursement methodology or a level-of-care reimbursement methodology. Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the sum of the DRG rate, the capital rate, and if applicable, the medical education rate, and outlier payment amounts. Payment for inpatient stays reimbursed as LOC cases shall be equal to the sum of the per diem rate for each Medicaid day, the capital rate, and if applicable, the medical education rate. Prospective payment under this system shall constitute full reimbursement. There shall be no year-end cost settlement payments.

DRG

Inpatient stays reimbursed according to the DRG methodology shall be assigned to a DRG using the all patient DRG grouper (currently Version 11 of the All-Patient Grouper developed by 3M Health Information Systems). The DRG rate is equal to the relative weight multiplied by the base amount.

"Relative Weight" is the numeric value which reflects the relative resource consumption for the DRG to which it is assigned. Upon implementation of the DRG reimbursement system, initial relative weights were calculated using Indiana Medicaid claims for inpatient stays in fiscal years 1990, 1991 and 1992 and cost report data in facilities' fiscal year 1990 cost reports. Relative weights will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. DRG average length of stay values will be revised when relative weights are adjusted.

"The Base Amount" is the rate per Medicaid stay. Upon implementation of the DRG reimbursement system, the initial base amount was calculated using cost report data from facilities' fiscal year 1990 as-settled cost reports. Cost report data were inflated to the midpoint of the state fiscal year 1995 using the DRI/McGraw Hill Hospital Market Basket Index available at the end of the 1993 calendar year. The DRG base amounts will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. In the absence of rebasing, the base amounts will be inflated annually effective on July 1, to the midpoint of that State Fiscal Year using the most recently available DRI/McGraw Hill Hospital Market Basket Index published in the second quarter of the current year. The office may establish separate base amounts for children's hospitals to the extent necessary to reflect significant differences in cost.

A **"level-of-care"** case (LOC) means a medical stay that is not part of the DRG reimbursement system. These cases include psychiatric cases, rehabilitation cases and certain burn cases.

"Level-of-care rates" are per diem rates. Upon implementation of the DRG/LOC reimbursement system, the initial level-of-care payment rates were calculated using Indiana Medicaid claims data for inpatient stays within state fiscal years 1990, 1991 and 1992 and cost report data from facilities' fiscal year 1990 cost

reports. Cost report data were inflated to the midpoint of the state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index. Level-of-care rates will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. In the absence of rebasing, level-of-care rates will be inflated annually according to the hospital market basket index published in the second quarter of the current year. The office may establish separate level-of-care rates for in-state children's hospitals to the extent necessary to reflect significant differences in cost.

"Capital Payment" rates cover capital costs. Capital costs are costs associated with the ownership of capital and include the following:

* Depreciation
* Interest
* Property Taxes
* Property insurance

Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. Upon implementation of the DRG/LOC reimbursement system the initial flat, statewide per diem capital rate was calculated using cost report data from facilities' fiscal year 1990 cost reports, inflated to the midpoint of state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index and adjusted to reflect a minimum occupancy level for non-nursing beds of 80 percent. Capital per diem rates will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the capital costs associated with efficiently providing hospital services. In the absence of rebasing, the per diem capital rate will be inflated annually using the Hospital Market Basket Index published in the second quarter of the current year.

The capital payment amount for Medicaid is:

* for stays reimbursed under the DRG methodology, equal to the product of the per diem capital rate and the average length of stay for all cases within the particular DRG. Capital payments shall be pro-rated for a transferring facility to a maximum of the average length of stay.

* for stays reimbursed under the level-of-care methodology, the per diem capital rate for each covered day of care.

"Medical Education" rates shall be prospective, hospital-specific per diem amounts. Medical education payment amounts for stays reimbursed under the:

* DRG methodology, shall be equal to the product of the medical education per diem rate and the average length of stay for the DRG. Medical education rates for a transferring facility shall be pro-rated not to exceed the average length of stay.

* Level-of-care methodology, shall be equal to the medical education per diem rate for each covered day of care.

Medical education rates are "facility-specific rates based on costs per resident per day multiplied by the number of residents reported by the facility. Initial costs per resident day were determined according to each facility's fiscal year